nize the psychogenic component for the illness but elects to disregard it and treat it as a straightforward organic illness, thereby supporting the patient's displacement of stress onto a somatic target. Since the stress is not dealt with, and since the organic illness is supported, the complaints continue and intensify over time.

There are notable examples of such illness—peptic ulcer disease is a good one. This is a stress-related disease that most physicians treat organically. Globus hystericus is another example of a disease that is invariably stress-induced and that the unsuspecting physician worsens by ordering barium swallows, esophageal manometrics, endoscopies, and follow-up appointments for the sole purpose of physical examination. More flagrant examples are the myofascial pain syndromes. Temporomandibular joint pain is an excellent example of such an illness.

The frequency of iatrogenic illness is debated. Those unskilled at diagnosis will tell you it is infrequent, if not altogether nonexistent. Those in primary care, sensitive to such problems, will tell you that 50% of what they see is stress-related, and by inference, those same patients, in the hands of someone not sensitive to psychogenic illness, will be dealing with 50% iatrogenic illness—the irony, of course, is that the illnesses are their iatrony.

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The War on Drugs

To THE EDITOR: What is "the war on drugs"? We think it is a fight against

- noncriminal (except that they use illegal drugs) addicts who buy the drugs;
- noncriminal nonaddicts who buy the drugs;
- organized crime (suppliers); and
- criminals who steal to continue their habit (users).

We could eliminate all but one of these adversaries—the "noncriminal" addicts—simply by decriminalizing illegal drugs. As a profession and as a society we do need to fight addiction, in the sense of helping addicts if we can. If drugs were decriminalized, we would still have that battle to wage, as we do today, but probably with not many more enemies.

Well-known political figures, such as George Schultz, are seeing the wisdom of decriminalization. The war on drugs is a war we cannot win, any more than we could win the fight against alcohol during Prohibition. If the money spent on the war against drugs were diverted to treatment for addiction, the medical profession would profit. More important, addicts and society as a whole would be a lot better off. We think it is time the medical profession took a medical and sensible stand on this subject.

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The Eye of the Beholder

To THE EDITOR: This is in response to the letter by Dr Arthur Vall-Spinosa in the December 1989 issue.[1]

"Glowing accounts" are somewhat in the eye of the beholder. I am very enthusiastic about a system in the United States that would permit the entire population to have access to decent medical care. Whether the Canadian health care system is the model we should emulate is open to question. There are clearly problems with the Canadian system, and transplantation to the United States might be very difficult.

Incidentally, there are not "tight limits" on the number of physicians in Canada. This was tried in British Columbia but thrown out in the courts. Certainly, the malpractice specter contributes to the cost of medicine in the United States, but it is not the major obstacle to a cost-effective national health care program.

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Tryptophan Use and Fasciitis

To THE EDITOR: Tryptophan, available both through health food stores and in pharmacies as a soporific, has recently been associated with eosinophilia and myalgias.[1] We report three cases and the biopsy findings of an eosinophilic fasciitis-like process associated with inflammatory myopathy.

Report of Cases

The patient, a 52-year-old housewife, used 1,500 to 3,000 mg of tryptophan nightly for five years and only recently developed myalgia of her upper and lower extremities. Her creatine kinase level was normal and a complete blood count showed a total leukocyte count of 26.0×10^9 per liter with 0.45 eosinophils. A biopsy specimen of gastrocnemius muscle showed macrophages, lymphocytes, and eosinophils invading the perimysium and endomysium (Figure 1). The muscle fibers themselves appeared relatively normal, but stains for adenosine triphosphatase showed fiber type grouping.

The second patient, a 29-year-old woman, had been taking 1,500 mg of tryptophan two to three times a week to help her sleep. Progressively worsening myalgias developed, associated with a red rash and a leukocyte count of 17.6×10^9 per liter with 0.56 eosinophils. A biopsy specimen of right gastrocnemius muscle showed an inflammatory infiltrate composed of a mixture of lymphocytes, macrophages, eosinophils, and plasma cells in the fascia with spillage into the perimysium and adipose tissue. The perineurium of several nerves in the specimen showed prominent inflammatory infiltrates. Staining for adenosine triphosphatase disclosed fiber type II predominance.

The third case is most intriguing as the patient presented in 1985 with a livedo-type rash on her anterior thighs and complaints of diffuse myalgia associated with low-grade fever and 0.3 peripheral eosinophilia. A creatine kinase level was normal. She had been taking as much as 3,000 mg of tryptophan each night to help her sleep. A biopsy specimen of right gastrocnemius at that time showed a scattered in-

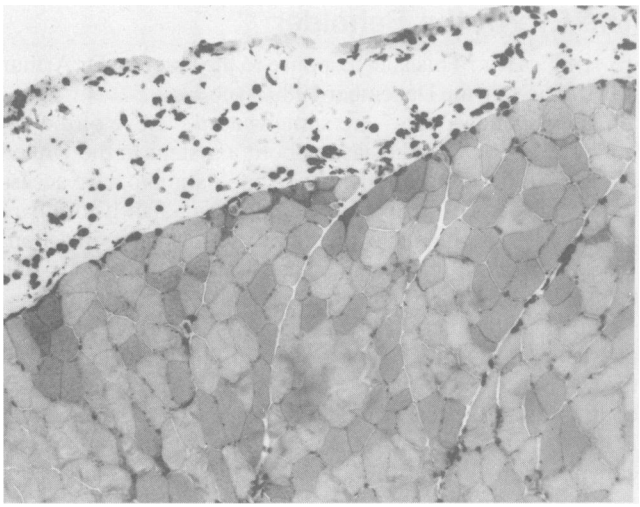

Figure 1.—Nonspecific esterase reaction highlights the inflammatory cells in the perimysium and endomysium (original magnification ×40).

flammatory infiltrate consisting primarily of lymphocytes and macrophages with occasional eosinophils. These cells were found in the epimysium, perimysium, and endomysium where they were particularly prominent around blood vessels and small nerves. Adenosine triphosphatase staining showed pronounced fiber type I predominance and denervation atrophy.

The pathologic examination in all three cases showed relative preservation of muscle fibers although there was a disturbance of fiber type distribution. Connective tissue within muscle fascicles as well as fascia and fat, when present, was variably infiltrated by inflammatory cells, including eosinophils. None of the biopsy specimens showed evidence of vasculitis. We noticed a propensity for the infiltrate to involve nerves and, in the second case, there was severe involvement of a muscle spindle. Nobuhiko and coworkers suggested that eosinophil-derived substances are neurotoxic and may play a role in the peripheral neuropathy associated with the hypereosinophilia syndromes.[2] A possible neuropathic component to the myalgias associated with tryptophan use warrants further investigation, particularly in light of the reported Guillain-Barré-like symptoms in some patients.[1]

Much of the clinical history and physical findings, as well as histologic features, seem indistinguishable from eosinophilic fasciitis, a disease of unknown etiology that has been reported since 1974.[3] Whether this tryptophan-associated fasciitis-like process is directly attributable to tryptophan use or is due to an unknown precipitating factor remains to be resolved. The third case raises the question of when this epidemic actually began.

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Integration of Prevention Efforts

To THE EDITOR: We read with interest the editorial by Dr Judson[1] that accompanied our report on efforts to control a recent outbreak of penicillinase-producing *Neisseria gonorrhoeae* (PPNG) in California.[2] Since the purpose of our report was to only briefly describe the 1987 PPNG epidemic in southern California and make some gonorrhea-specific recommendations, we made no attempt to discuss the issues addressed by Dr Judson, especially with regard to the need to integrate traditional sexually transmitted disease (STD) and human immunodeficiency virus (HIV) prevention efforts. We agree, however, that this is an important issue, and we would take this opportunity to comment on how the California Department of Health Services (CDHS) has tried to integrate STD and HIV prevention efforts.

The need to integrate traditional sexually transmitted disease prevention efforts (along with drug abuse prevention and treatment and various other activities) with HIV prevention efforts has long been recognized by the CDHS. We have repeatedly made this point in the past several years at many medical and non-medical forums. Indeed, this point was stressed in our response to the California legislature during its consideration a few years ago of creating a separate state department of AIDS (acquired immunodeficiency syndrome). We have strongly resisted efforts such as this because of our belief that there is a critical need to integrate HIV disease prevention efforts with numerous other public health and publicly funded health care programs.

Our specific efforts to integrate HIV and other STD prevention efforts include the following:

- All of our STD intervention staff have been trained in HIV pre- and post-test counseling techniques, and they integrate risk assessment and behavior messages into the STD interview process.
- Confidential HIV antibody testing is offered, along with routine pretest counseling, to every STD clinic patient. Assistance in notification of sex or needle-sharing partners, or both, is provided to patients with positive test results.
- Program managers for STD regularly influence HIV-related policy through a long-standing interagency AIDS planning committee, as well as through other intradepartmental processes.
- Traditional STD and HIV prevention efforts have been combined to conduct knowledge, attitudes, beliefs, and behaviors surveys in STD clinics and to strengthen outreach activities to high risk groups through demonstration projects with community-based organizations. Current projects involve STD and HIV screening targeted to inner-city pregnant women, many of whom are addicted to crack cocaine. Other projects offer testing for infectious diseases common to addicts seen at drug rehabilitation centers.
- Sexually transmitted disease and HIV disease are jointly targeted in California's public information campaigns, and both programs have helped formulate health education criteria in the public school system.

Despite the fact that policy and funding decisions by state and federal elected officials have forced the separation of HIV disease and other STD prevention programs, multiple